EXPANDED ACCESS TO PRIMARY CARE (EAPC) PROGRAM

REQUEST FOR RENEWAL FUNDING

FISCAL YEAR 2005-2006

PRIMARY and RURAL
HEALTH CARE SYSTEMS

CALIFORNIA DEPARTMENT OF HEALTH SERVICES

APPLICANT INSTRUCTIONS

Purpose

The purpose of this application is to provide instructions and forms necessary to apply for ***renewed*** EAPC funding for fiscal year (FY) 2005-2006.

Format assembly and submission

Refer to the top of each form for completion instructions.

Applications must be submitted in typewritten form. Upon completion, assemble the application including all required forms and documents in the order listed on the Application Checklist (page 7). Clearly label each page number in the upper right corner and staple the completed packet in the upper left corner. Include only the information requested in this application. Please do not return the application in a special cover or binder.

Mail the **original** application and **one copy** to the following address:

California Department of Health Services
Expanded Access to Primary Care Program
1615 Capitol Avenue
MS 8500
P.O. Box ~~997431~~ 997413
Sacramento, CA 95899-7413

Special instructions

Please read the instructions for each page carefully. Each page requires specific information:

- Page 3 requires information regarding the Corporation.
- Pages 4 -6 require information from ALL clinic sites requesting EAPC funding, including newly eligible clinic sites.

Note: All clinics must continue to operate under the provisions and requirements set forth in the EAPC Request for Application Fiscal Years 2004-2007, e.g., clinic and patient population criteria, billing processes, type of service, redistribution criteria.

Due date

Applications must be **postmarked** no later than **June 17, 2005.**

Facsimile

Applications transmitted by facsimile (FAX) will not be accepted.

EAPC Web site

This application may be viewed and downloaded from the EAPC Web site: **http://www.dhs.ca.gov/eapc**

Signatures

All signatures must be in **blue ink**.

APPLICANT INSTRUCTIONS
(continued)

Application evaluation

All applications will be evaluated prior to distribution of renewed funding to determine if all criteria set forth in Health and Safety Code Section 124910 (d) are met.

Appeals process

Any applicant not selected for this funding will be notified of the denial in writing. Applicants denied funding may appeal DHS's decision. The appeal/grievance process is set forth below.

Grievance

A grievance exists when an applicant believes there is a dispute arising from DHS's action in awarding or failing to award an allocation. Grievous situations include actions to continue or failure to continue the agreement into a new funding cycle and actions to terminate an existing agreement prior to the stated expiration date.

Within 15 working days of notification of an alleged action by DHS, the applicant must direct the grievance in writing to the Deputy Director under which the action occurred. The grievance must state the issues in dispute, the legal authority or other basis for the applicant's position, and the remedy sought. The Deputy Director or designee must respond to an applicant's appeal within 20 working days of receipt of the grievance and a hearing must be scheduled, conducted, and a decision rendered by DHS within 60 working days of the filing of the grievance by the applicant. The decision of the Deputy Director or the designee shall be final. There is no further administrative appeal.

Send appeals to:

Catherine Camacho, Deputy Director
California Department of Health Services
Primary Care and Family Health
1501 Capitol Avenue
MS 8000
P.O. Box 942732
Sacramento, CA 94234-7320

EAPC RENEWAL APPLICATION COVER SHEET
FY 2005-2006

CORPORATE INFORMATION

Legal Corporate Name **(Type exactly as the name appears on the State license)**		**EAPC Provider #**	
Corporate WEB SITE Address		**Federal Employer ID Number**	
Corporate Telephone Number		**FAX Number**	
Executive Director	**Telephone Number** (if different than corporate)		
Corporate (Mail Delivery) Address	**City**	**County**	**Zip Code**
Corporate Street Address (If different than mailing address)	**City**	**County**	**Zip Code**
Number of clinic sites for which the Corporation is requesting funding:_____			
EAPC Contact Person (individual to contact regarding this application **and/or** any EAPC related questions)		**Telephone Number** **( )**	
E-MAIL ADDRESS: (Where clinics can receive information/updates, etc.)			

CERTIFICATION

The undersigned hereby certifies under penalty of perjury and on behalf of the applicant that the information provided in this application is true, correct, and complete. The applicant agrees to comply in accordance with the statutes and the program requirements of the Expanded Access to Primary Care Program.

Signature of Executive Director	**Date Signed**

CLINIC SITE INFORMATION

INSTRUCTIONS

Complete this form for each clinic site. Duplicate form as needed.

Legal Corporation Name		**Office of Statewide Health Planning and Development (OSHPD) 9 digit ID Number**	
Clinic Site Name		**Clinic Telephone** **( )**	
Clinic Street Address	**City**	**County**	**Zip Code**
Medi-Cal Number	**Is this a school-based clinic** **Yes □ No □**	**Is clinic exempt from licensure per Health and Safety Code 1206 (c)*. Yes □ No □**	

Unless exempt*, attach a <u>copy</u> of the above clinic's state license to this page

***Licensure Exemptions: "Any clinic conducted, maintained, or operated by a federally recognized Indian tribe or tribal organization, and which is located on land recognized by the federal government."**

CERTIFICATION OF SERVICES TO A MEDICALLY UNDERSERVED AREA OR POPULATION (MUA/MUP)

Legal Corporate Name	Clinic Site Name

INSTRUCTIONS
Complete this form for each clinic site. Duplicate form as needed.

EAPC clinics must meet one of the following conditions:

CHECK THE APPROPRIATE BOX BELOW:

☐ Clinic is located in a federal or state designated medically underserved area (MUA) or medically underserved population (MUP) as documented by one of the following:

- A copy of the designation letter from the U.S. Department of Health and Human Services, Bureau of Primary Care Services, Division of Shortage Designation,

OR

- Printouts detailing the MUA/MUP designation for the clinic's census tract. (Please follow instructions on Appendix A).

☐ Clinic is able to demonstrate that at least 50 percent of the patients served are persons with incomes at or below 200 percent of the federal poverty level as reported to the Office of Statewide Health Planning and Development (OSHPD).

- Most recent calendar year data available: _____
- Number of patients that are at or below 200% of the federal poverty level for the clinic site indicated above. _____
- Percentage of the total clinic population who are at or below 200 percent of the federal poverty level*. _____ **%**

*The 2005 Federal Poverty Level Guidelines can be found at the United States Department of Health and Human Services website: http://aspe.hhs.gov/poverty/05poverty.shtml

CERTIFICATION

The undersigned hereby certifies that the clinic site identified above provides primary health care services to a medically underserved area or population or that 50% or more of this patient population is at or below 200% of the federal poverty level.

Executive Director Signature	Typed Name	Date Signed

CERTIFICATION OF UNCOMPENSATED CARE ENCOUNTERS

Legal Corporate Name	Clinic Site Name	OSHPD ID #

INSTRUCTIONS

Complete this form for <u>EACH</u> clinic site.

For the purpose of the EAPC Program an ***"uncompensated care" (UCC)*** encounter is defined as a visit with a medical practitioner for examination or treatment for a person with an income at or below 200 percent of the Federal Poverty Level (FPL) for which there is no third party reimbursement. Third party reimbursement includes unpaid EAPC claims as well as other unreimbursed visits.

For calendar year 2004, provide the total number of UCC encounters for each category listed below. The calendar year 2004 data requested is available in the **"Annual Utilization Report of Primary Care Clinics for *Calendar Year 2004."*** Refer to Section 6, entitled "*Revenue and Utilization by Payer*."

UNCOMPENSATED CARE ENCOUNTERS	
Self-Pay/Sliding Fee (Section 6 (1); Line 1;Column 8)	
Free Patients (Section 6 (1); Line 1; Column 9)	
EAPC Program (Section 6 (2); Line1; Column 12)	
TOTAL	

CERTIFICATION

The undersigned hereby certifies that the above information is true and correct, and that the number of encounters reported above are the same numbers that were reported to OSHPD in the Annual Utilization Report of Primary Care Clinics for Calendar Year 2004.

Executive Director (Original Signature)	Typed Name	Date Signed

APPLICATION CHECKLIST

Legal Corporate Name

INSTRUCTIONS

- **Include the applicable items in the application and make reference to the appropriate page number.**
- **If an item is not applicable indicate "N/A".**

ITEM	REFERENCE PAGE	PAGE
EAPC RENEWAL APPLICATION COVER SHEET	3	
CLINIC SITE INFORMATION INCLUDING COPY OF CURRENT CLINIC LICENSE FOR EACH SITE	4	
CERTIFICATION OF SERVICES TO A MEDICALLY UNDERSERVED AREA OR POPULATION (MUA/MUP)	5	
CERTIFICATION OF UNCOMPENSATED CARE ENCOUNTERS (for *each* clinic site)	6	

APPENDIX A

To find out if the clinic is in a federally designated Medically Underserved Area (MUA) or Medically Underserved Population (MUP) please follow the instructions below. Note, that MUAs and MUPs are listed by census tract. Therefore, you must first determine the clinic's census tract.

To find out what census tract your clinic is located in:

1. **Access the U.S. Census bureau's website at: http://factfinder.census.gov/home/saff/main.html**
2. **Below the menu options on the left side of the screen, select the "street address" option located in the box labeled Address search.**
3. **The first drop down box automatically shows 2000 Census tract, please enter the clinic site information in the following boxes and select "GO".**
4. **A box appears with information regarding the clinic site. In the middle of the box, the information labeled "Census Tract" gives the specific census tract for the clinic.**
5. **Please print a copy of this page, with the clinic's census tract clearly highlighted, and include it with your application.**

To find out if your census tract is a designated MUA/MUP:

1. **Access the US Department of Health and Human Services HRSA website at: http://bhpr.hrsa.gov/shortage/index.htm**
2. **Scroll down and select the link labeled "Search the MUA/MUP data base".**
3. **Enter the clinic's state and county in the appropriate boxes. (It is not necessary to have the ID number)**
4. **The resulting screen will have information on MUA/MUP designations; however, by selecting each of the blue highlighted areas, a breakdown will appear by census tract.**
5. **Once you have found the census tract corresponding to the clinic area, please print out the page with the clinic's census tract. Highlight the clinic's census tract, and include a copy of this printout with your application.**